MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

CERTIFICATE OF DEATH

11212

Reg. Dist. No. 2370

1. PLACE OF DEATH:
County Prince Georges
City or town Brandywine Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince Georges
City or town Brandywine R.F.D
(If outside city or town limits, write RURAL and give nearest town)
Street No. Baden Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Herbert Martin Adams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Mary Catherine Adams
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 21-1865

8. AGE: Years 81 | Months 3 | Days 9 | If less than one day hrs. min.

9. Birthplace Gallant Green Charles Co
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Joseph Adams

FATHER 12. Name Joseph Adams
13. Birthplace Don't Know

MOTHER 14. Maiden name Mrs Rebecca Martin
15. Birthplace Prince Georges

16. Informant George Adams
Address Brandywine Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-3-46 (month) (day) (year)
Cemetery or crematory St. Paul
Location Baden md

18. Funeral director Hunt & Ryon
Address Waldorf Md

19. 12-2 19 46 M L Sloan Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1946, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on Nov 30 1946, to 19
and that I last saw him alive on Nov. 30 1946

Immediate cause of death	DURATION
Angina Pectoris	4 hrs.
Due to Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John E. Bowers M.D.
M. D. or other
Address Brandywine, Md Date signed 11/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11213

Reg. Dist. No. 2142

1. PLACE OF DEATH:
County: Prince Georges
City or town: Ritchie, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: Prince Georges County Almshouse
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Georges
City or town: Ritchie, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Prince Geo. County Almshouse
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Peter W. Allen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	W

6.(b) Name of husband or wife: Josephine Day
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE: Years: 85 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Swvatts, Md (town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:

FATHER
12. Name: Nathaniel Allen
13. Birthplace: Clinton, Md

MOTHER
14. Maiden name: Emma Pannell
15. Birthplace: Swvatts, Md

16. Informant: Institution Records
Address: Ritchie Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22-46 (month) (day) (year)
Cemetery or crematory: Bells M.E. Church Cemetery
Location: Camp Springs Md
18. Funeral director: Thos. F. Murray Funeral Home
Address: 2007 Nicholson St. S.E.

19. 11-20 19 46 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov - 20 19 46, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 42, to Nov 20 1946, and that I last saw him alive on Nov 14 19 46.

Immediate cause of death	OURATION
Hypertensive heart disease	2
Due to	
Due to	
Other conditions: Epilepsy	7

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John J. Maloney M.D. M. D. or other
Address: Cheverly, Md Date signed: 11-20-46

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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2-2420

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11214

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6111 Arbor St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jessie E. Armstrong

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife George Armstrong
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 15 1880

8. AGE: Years	Months	Days	If less than one day
66			..... hrs. ..... min.

9. Birthplace Dana Iowa Iowa
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER 12. Name	Joseph Davis
FATHER 13. Birthplace	Vermont
MOTHER 14. Maiden name	Jennie Cookingham
MOTHER 15. Birthplace	N.Y.

16. Informant Mrs. Lucile Elkins, dtr.
Address 6111 Arbor St. Cheverly, Md.
17. Burial
(Burial, cremation, or removal. Which?) Date thereof 11/25/46 (month) (day) (year)
Cemetery or crematory Ft. Lincoln Cemetery
Location Washington, D.C.
18. Funeral director Zero Cleaners Co
Address Riverdale, Md.
19. 11/24 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1946 at 12:25 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1946 to June 21 1946
and that I last saw h[illegible] alive on June 21 1946

	DURATION
Immediate cause of death Metastatic carcinoma with ascites	4 mths
Due to Primary carcinoma of stomach	about 6 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Carcinoma of stomach
Date of op. July 25, 1946
Autopsy results No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE George H. McLain, M.D
M. D. or other
Address 1740 K. N.W. Date signed June 22-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

★ 11215

Reg. Diat. No. 2451

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5 C Ridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Asher Berkowitz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary Berkowitz
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1879

8. AGE: Years	Months	Days	If less than one day
67	9	8	...hrs. ...min.

9. Birthplace: Rumania (Town, county, and state)
10. Usual occupation: Proprietor of store
11. Industry or business:

FATHER
12. Name: Copel
13. Birthplace: Rumania

MOTHER
14. Maiden name: Sophia
15. Birthplace: Russia

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal? Which?) Date thereof: 11/24/46 (month) (day) (year)
Cemetery or crematory: New York City
Location: New York
18. Funeral director: W W Chambers Co
Address: Riverdale, Md.

19. NOV 24 1946 (Date rec'd by registrar) Mrs. Jas. Devere Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23, 1946, at 6 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from: Apr 25 1945, to Nov. 23, 1946
and that I last saw h.2.in...alive on: November 23, 1946

Immediate cause of death	DURATION
Coronary Thrombosis	7 days
Due to: Arteriosclerosis, general.	10 years
Due to:	
Other conditions: diabetes mellitus	30 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hans Wodak, M.D. M. D. or other
Address: 30 Ridge Rd, Greenbelt, Md Date signed: 11-23-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 - 25

2 - 2450 - 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

11216

Reg. Dist. No. 2320

1. PLACE OF DEATH:

County: Prince George

City or town: Ritchie (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred: Pr. Geo Co Almshouse

How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Pr. Geo.

City or town: Mitchellville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Samuel Bitting

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Isabella Ulmer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1866

8. AGE:

Years	Months	Days	If less than one day
80	7	5	hrs. min.

9. Birthplace: Lebanon Pa. (Town, county, and state)

10. Usual occupation: Egg inspector

11. Industry or business:

FATHER — 12. Name: Jacob Bitting

FATHER — 13. Birthplace: Reading Pa.

MOTHER — 14. Maiden name: Nancy Ann Rupp

MOTHER — 15. Birthplace: Lebanon Pa

16. Informant: Pr. Geo Co Almshouse

Address: Ritchie Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-16-46 (month) (day) (year)

Cemetery or crematory: Ellinhand

Location: Forestville, Md.

18. Funeral director: Ritchie Brothers

Address: Upper Marlboro Md.

19. NOV 15 1946 (Date rec'd by registrar) R. Bruce Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14 1946, at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941, to Nov 14 1946 and that I last saw h.i.m. alive on Nov 7 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John D. Maloney, M. D. (M. D. or other)

Address: Beverly-Hyattsville Date signed: 11-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

11217

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince George Co.
City or town: Mt Rainer
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mt Rainer
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3005 Bunker Hill Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CARL Bock

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Ada D R.
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): July 5, 1874

8. AGE: Years: 72 Months: Days: If less than one day: hrs. min.

9. Birthplace: Sulphur Springs Indiana (Town, county, and state)

10. Usual occupation: U.S. Govt.

11. Industry or business

FATHER
12. Name: Christopher Bock
13. Birthplace: Indiana

MOTHER
14. Maiden name: Eliza Benbow
15. Birthplace: Indiana

16. Informant: Carl R. Bock
Address: Randonia Hills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-16-46 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Wash. D.C.

18. Funeral director: W. W. Chambers & S.
Address: Riverdale Md.

19. Nov. 16 1946 (Date rec'd by registrar) Mrs. Jas. Devere Deputy, Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 Nov. 46 19 46 at 12 50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Nov. 1946 to 14 Nov 1946 and that I last saw h alive on 14 Nov. 46. 19

Immediate cause of death	Coronary occlusion	5 hours
Due to	Not previously accounted for	
Due to	Lee Remarks	
Other conditions		

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas D Mattingly M.D.
M. D. or other
Address: 2200 R.I. Ave N.E. Date signed: 14 Nov. 1946

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Deceased was seen shortly after typical onset of coronary occlusion or myocardial infarction. He was in shock with orthopnea and characteristic precordial angina of extreme degree. Dr. James D. Boyd was called and acquainted with above facts and gave permission to sign certificate pending his subsequent approval.

James B. Mattingly, M. D.

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2-2450

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11218

Reg. Diat. No. 2450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Cottage City, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3704 - 37th Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julia P. Boswell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	white	widowed

6.(b) Name of husband or wife: William Collier Boswell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 7th, 1862

8. AGE: Years	Months	Days	If less than one day
84			..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER
12. Name: Charles Adolph Krauss
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Pitt
15. Birthplace: unknown

16. Informant: Mrs. Rosa E. Gray
Address: 3704 - 37th Place Cottage City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 30/46 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg Rd. - D.C. Line

18. Funeral director: Wm. J. Malley
Address: 522 - 8th St. S.E. Wash. D.C.

19. Nov 29 1946 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1946, at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1939, to Nov 28 1946
and that I last saw her alive on Nov 27 1946

Immediate cause of death	DURATION
cerebral hemorrhage	
Due to: gen. arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M. Schwartzman M. D.
Address: 2015 Nichols St. Date signed: 11/29/46

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

2 — 11219 — Reg. Dist. No. 2371

1. PLACE OF DEATH:
County: Prince George
City or town: Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rosie E. Brady

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W. dowed

6.(b) Name of husband or wife: Geo. A. Brady
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov - 29 - 1867

8. AGE: Years	Months	Days	If less than one day
78	10	5	hrs. min.

9. Birthplace: Cheltenham Md
(Town, county, and state)
10. Usual occupation: Home - wife
11. Industry or business

FATHER
12. Name: Wm. H. Bowlers
13. Birthplace: Pr. Geo - County

MOTHER
14. Maiden name: Catherine Thomas
15. Birthplace: Pr. Geo. County

16. Informant: Emily A. Bowlers
Address: Clinton

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-7-46. (month) (day) (year)
Cemetery or crematory: St. Thomas
Location: Croom, Md.
18. Funeral director: Ritchie Bros.
Address: Upper Marlboro Md.
19. Nov 6 1946 (Date rec'd by registrar) James B Naylor Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov - 4 1946, at 9.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death: Cortico sclerotic heart disease

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John J. Maloney M.D.
M. D. or other
acting Deputy medical examiner
Address: Cheverly, Md. Date signed 11-5-46

2-25

2-2370

2-10

Evidence for the change of sur name is shown on 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-a

CERTIFICATE OF DEATH

★ 11220

FILM No. I 08 NOV 18 1946

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Prince George's Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Mt. Rainer
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3824-34th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: IDA BRETTSTEIN (Bretstein)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62				

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Ezekiel Breitstein
13. Birthplace: Russia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Russia

16. Informant: Mrs. Bessie B. Lavine
Address: 3824 34th St., Mt. Rainer Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1946 (month) (day) (year)
Cemetery or crematory: Eversovetgrad Cemetery
Location: Washington, D.C.

18. Funeral director: B. Wainaweky & Son
Address: 3501-14 Eldorado

19. 11/7 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 1946, at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28, 1946, to November 7, 1946
and that I last saw h.e.r alive on November 6, 1946

Immediate cause of death	DURATION
Bronchopneumonia	1 week
Due to: Toxemia from absorption of necrotic tissue - decubitus ulcer	One month
Due to:	
Other conditions: FRACTURE OF RIGHT HIP	5½ weeks
FRACTURE OF RIGHT SHOULDER	5½ weeks

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Mt. Rainier, Md. Date signed 11/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11221

CERTIFICATE OF DEATH

Reg. Diat. No. 2431

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1104- G. St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: EDWARD ARTHUR BROWN

3. (b) Social Security Number: 214-16-7778

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Hattie E. Brown
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): January 23, 1896

8. AGE:

Years	Months	Days	If less than one day
50	10	4	... hrs. ... min.

9. Birthplace: Prince George's Co., Maryland
(Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business:

FATHER
12. Name: Pleasant Brown
13. Birthplace: Prince George's Co., Maryland

MOTHER
14. Maiden name: Ardeen Franklin
15. Birthplace: Sandy Springs, Maryland

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11-29-46 (month) (day) (year)
Cemetery or crematory: To Washington DC
Location:

18. Funeral director: W. Ernest Jarvis Co
Address: 1432 Q St NW.

19. Nov. 27 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1946, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 1946 to Nov. 27 1946
and that I last saw h. l. in. alive on Nov. 27 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hours
Diabetes Mellitus, severe	10 mos.
Due to: Gangrene, diabetic, left leg	5 da.
Due to: Pulmonary tuberculosis	6 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Md. Date signed: 11-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

★1222

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 hours
Hospital, Institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? 27 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: — County: —
City or town: Washington, D. C. (If outside city or town limits, write RURAL and give nearest town)
Street No. 1615 Kenyon St. N.W. (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME William Boyd CARNES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Mathilde Carnes
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 5, 1883

8. AGE:

Years	Months	Days	If less than one day
63	5	11	— hrs. — min.

9. Birthplace: Big Stone Gap, Va. (Town, county, and state)
10. Usual occupation: Retired.
11. Industry or business

FATHER — 12. Name	William Carnes
FATHER — 13. Birthplace	Va.
MOTHER — 14. Maiden name	Emma Marton
MOTHER — 15. Birthplace	Va.

16. Informant: William Boyd Carnes, Jr.
Address: Atlanta, Ga.
17. Transportation (Burial, cremation, or removal. Which?) Date thereof Nov. 17, 1946 (month) (day) (year)
Cemetery or crematory: Big Stone Gap, Va.
Location: Virginia
16. Funeral director: G. F. Jones Co.
Address: 2901 - 14th St. N.W.
19. 11/17/46 (Date rec'd by registrar) Amanda Downs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16, 1946, at 6 05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1946 3:00 P.M. to Nov. 16, 1946 and that I last saw h[illegible] alive on November 16, 1946.

	DURATION
Immediate cause of death: Pulmonary edema. Hypostatic Congestion and Pneumonia	27 hours
Due to: Cardiac failure	Same
Due to: Atheromatous aneurysmal degenerative aortitis - Cause unknown	unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Same autopsy 11/17/46
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Mt. Rainier, Md. Date signed 11/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11223

Reg. Diat. No. 239

1. PLACE OF DEATH:

County: Prince George

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:
319 Laurel Ave

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Prince George

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. 319 Laurel Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas Otho Clough

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Annie L Leister

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): February 24, 1867

8. AGE: Years: 79 | Months: 9 | Days: 3 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Laurel Prince Geo. Co. Md
(Town, county, and state)

10. Usual occupation: machinist retired

11. Industry or business:

FATHER
12. Name: Charles H. Clough
13. Birthplace: England

MOTHER
14. Maiden name: Elizabeth Saffel
15. Birthplace: unknown

16. Informant: Gilbert T. Murphy
Address: 319 Laurel Ave. Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 26/1946 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md

18. Funeral director: The H. C. Hartsock Co.

Address: Laurel Md.

19. 11-26 1946 (Date rec'd by registrar) Cora E. Wadelton Deputy. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 1946, at 12 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24 1946, to Nov 24 1946

and that I last saw him alive on Nov 24 1946

Immediate cause of death	DURATION
Coronary occlusion	1 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: W B Hartsock M.D.

Address: 322 Main St Laurel Md. Date signed: 11/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-21

2-2390 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (146-P)

CERTIFICATE OF DEATH

(over)

11224 — Reg. Dist. No. 245 / 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Prince George County
City or town: Riverdale, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 hr.
Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hosp.
How long in hospital or institution? 32 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
Street No.: Brooklyn Bridge Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Cole, Mrs. Hazel Irene
3.(b) Social Security Number:

4. Sex: F
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Mr. Henry Cole
6.(c) If alive, give age: 28 years
7. Birth date of deceased (mo., day, yr.): Nov. 25, 1921

8. AGE: Years	Months	Days	If less than one day
24	11	28	......hrs. ......min.

9. Birthplace: Savage, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home
FATHER 12. Name: George W. Reedy
13. Birthplace: ?, Va.
MOTHER 14. Maiden name: Daisy May Fitch
15. Birthplace: ?, Md.
16. Informant: Leland Memorial Hosp. Records
Address: Riverdale, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-24-46 (month) (day) (year)
Cemetery or crematory: Emanuel Cemetery
Location: Scaggsville Md.
18. Funeral director: DeWitt Donaldson
Address: Laurel Md
19. Nov. 22 1946 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 — 1946, at 5:9 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1946, to Nov 22 1946
and that I last saw her alive on Nov 22 1946

	DURATION
Immediate cause of death: Uterine Hemorrhage	4 hr
Due to: Premature Placental Separation	4 hr
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. B. Gruver M. D. or other
Address: 322 P. Gr. St. Laurel Date signed: 11/22/46

VS A15 9-45-15M

There was no Litch.
according to letter from N. O. Stewart. Ms.
Laurel. Ms.
his letter file - 12/23/46 P.R.C

1-25

2-2450 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11225

Reg. Diat. No. 2450

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Hyattsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5604 - 35 Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George E Connell Sr.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife: Laura Connell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 3, 1866

8. AGE: Years: 80 | Months: 8 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Laurel Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: John B Connell
13. Birthplace: Va.

MOTHER
14. Maiden name: Susan E. Owens.
15. Birthplace: Md.

16. Informant: Geo. E. Connell Jr.
Address: 716 - Rittenhouse NW

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-11-46 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Pr. Geo. Co.

18. Funeral director: W. Tee & Sons
Address: 360 - 4 St S.E. - D.C.

19. 11/8/46 (Date rec'd by registrar)
Amanda Downey
James Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7 19 46, at 12:55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John J. Mahoney M.D.
Acting Dep. Med. Examiner
M. D. or other
Address: Beltsville Md. Date signed 11-7-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157a)

CERTIFICATE OF DEATH

11226

Reg. Diat. No. 2420

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fairmount Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Died

Hospital, Institution, or street address where death occurred: 1019 Addison Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Fairmount Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1019 Addison Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Barbara Joyce Yvonne Crawford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 6, 1946

8. AGE: Years | Months: 10 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D.C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: James Crawford

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emma Harrison

15. Birthplace: Maryland

16. Informant: Beatrice Harrison

Address: 1019 Addison Rd, Fairmount Hgts

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 27, 46 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Washington D.C.

18. Funeral director: Henry G. Washington & Son

Address: 467 N St. N.W.

19. Nov 24 1946 (Date rec'd by registrar) Carrie T. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 19 46, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Cerebral Compression — DURATION

Due to: Hydrocephalus

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Greenbelt, Md. Date signed 11-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

11227

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince George 's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos., 21 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 422 - 11th St. S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: ELSIE E. CRAWFORD

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Robert Crawford
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): October 3, 1913

8. AGE: Years	Months	Days	If less than one day
33	1	21	...hrs. ...min.

9. Birthplace: Loudon County, West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Thomas H. Peterson
13. Birthplace: Loudon Co., West Virginia

MOTHER
14. Maiden name: Anita Cooper
15. Birthplace: Loudon Co., West Virginia

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: Nov 25, 1946 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Barnes & Matthews
Address: 614 - 4½ St. S. W.

19. Nov. 24, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24, 1946, at 9:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3, 1946, to Nov. 24, 1946
and that I last saw h... alive on Nov. 24, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs 3 Mo
Complications: -	
Left tuberculous empyema	2 yrs 10½ Mo
Due to: Left bronchopleural	6 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 11/24/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-2

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

11228

Reg. Dist. No. 2450

1. PLACE OF DEATH:
County: Prince George County
City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days.
Hospital, institution, or street address where death occurred: Casualty Plead Memorial Hosp.
How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George County
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4012 Hamilton St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Daly Mr. James Forrest

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Helen Daly
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): May 3, 1900

8. AGE: Years	Months	Days	If less than one day
46	6	23	...hrs. ...min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Auditor
11. Industry or business: Int. Revenue Bureau of

FATHER
12. Name: Harry Daly
13. Birthplace: Wash. D.C.

MOTHER
14. Maiden name: Harriet Forrest
15. Birthplace: New York.

16. Informant: Helen Allyson Daly
Address: 4012 Hamilton St. Hyattsville Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov 26 1946 (month) (day) (year)

Cemetery or crematory:
Location: 2901 - 14th St N.W. Wash D.C.

18. Funeral director: The S.H. Hines Co.
Address: 2901 14th St N.W.

19. Nov 26 1946 (Date rec'd by registrar) James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26, 1946, at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Pulmonary embolism	
Due to Crushed chest	
Due to Compound fracture of right thigh and fibula	
Other conditions Fracture left femoral head	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 11-21-46
Where did injury occur? Hyattsville P.G. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Hamilton St.
Means of injury: Car in collision injured at work as Deputy Sheriff
23. SIGNATURE: ... M. D.
Address: Hyattsville Md. Date signed 11-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

*1229

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 19 days.

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 months, 19 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 253 D. St., N. W. Apt. 13
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: JACKSON H. DOUGLAS

3. (b) Social Security Number: 238-18-0012

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Sara Douglas

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1916

8. AGE: Years	Months	Days	If less than one day
30	9	4	hrs. min.

9. Birthplace: Rock Hill, South Carolina
(Town, county, and state)

10. Usual occupation: Porter in Barber Shop

11. Industry or business:

FATHER
12. Name: John Douglas
13. Birthplace: Rock Hill, South Carolina

MOTHER
14. Maiden name: Amelia Shelley
15. Birthplace: Rock Hill, South Carolina

16. Informant: Deceased

Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof Nov 27, 1946 (month) (day) (year)

Cemetery or crematory: Washington, D. C.

Location:

18. Funeral director: Malcolm & Shehey Inc.

Address: 424 R. St. N.W.

19. Nov. 26 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/6/ 1946, to 11/26 1946

and that I last saw him alive on 11/26/ 1946.

Immediate cause of death	DURATION
Pulmonary tuberculosis	10 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 11/26/46

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

11230

Reg. Dist. No. 2450

1. PLACE OF DEATH:

County: Prince Georges

City or town: Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, Institution, or street address where death occurred:

3507-33rd Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3807-33rd Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nellie Mooney Elliott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James H. Elliott

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): June 12, 1881

8. AGE: Years: 65 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: William C. Mooney

FATHER — 13. Birthplace: Washington D.C.

MOTHER — 14. Maiden name: Annie Elizabeth Herbert

MOTHER — 15. Birthplace: Germany

18. Informant: James H. Elliott

Address: Mt Rainier Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/18/1946 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Bladensburg Rd. + D.C. Line

18. Funeral director: Wm. J. Malloy

Address: 3200 R.I. Ave. Mt. Rainier Md.

19. Nov 17 1946 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14 19 46 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions: Very obese	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

Report medical Examiner

23. SIGNATURE: James H. Ford M. D. or other

Address: Westville Md. Date signed 11-14-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ~~correct~~ age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11231

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 791 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 791 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. Cooty:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Eye St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ALMA FENWICK.

3.(b) Social Security Number: 578-30-7695

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26, 1925

8. AGE: Years	Months	Days	If less than one day
21	3	20	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Elevator Operator

11. Industry or business:

FATHER
12. Name: Jordan Fenwick
13. Birthplace: St. Mary's Co., Maryland

MOTHER
14. Maiden name: Louise M. Dawson
15. Birthplace: Spottsylvania Co., Virginia

16. Informant: Louise M. Fenwick, mother
Address: 216 Eye St., N. W.

17. Removal to Washington, D.C. Date thereof Nov. 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: R. H. Horton Co.
Address: 322 New York Ave.

19. Nov. 16, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1946, at 9:45 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from (Sept 15 1944 to Nov. 16 1946 and that I last saw her alive on Nov. 16 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs
Due to	3 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 11/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11232

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1820 Kalorama Road, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HANNIBAL FISHER.

3.(b) Social Security Number: 578-09-6411

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1910

8. AGE: Years	Months	Days	If less than one day
36	9	13	hrs. min.

9. Birthplace: Williamsburg, Pennsylvania
(Town, county, and state)

10. Usual occupation: Cleaner

11. Industry or business:

FATHER — 12. Name: Robert Fisher
13. Birthplace: Norfolk, Virginia

MOTHER — 14. Maiden name: Josephine Ingraham
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof Nov. 17, 1946 (month) (day) (year)

Cemetery or crematory:
Location: Washington, D. C.

18. Funeral director: Frazer Funeral Home Inc
Address: 984 R. I. Ave NW

19. Nov. 16, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16th 1946, at 4:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5th 1946, to Nov. 16th 1946, and that I last saw him alive on Nov. 16th 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 11/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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7-1

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

★ 11233

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George
City or town: Near Largo, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockcrest, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 917 - Lewis Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: (S)

3.(a) FULL NAME: Robert Joseph Frankenfield

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Jane W. Frankenfield

7. Birth date of deceased (mo., day, yr.): August 15, 1919 — 6.(c) If alive, give age ..... years — Aug 15, 1919

8. AGE:

Years	Months	Days	If less than one day
27	2	20	..... hrs. ..... min.

9. Birthplace: Fostoria, Ohio (Town, county, and state)
10. Usual occupation: Pilot (aviator)
11. Industry or business:

FATHER
12. Name: Carl Frankenfield
13. Birthplace: Ohio

MOTHER
14. Maiden name: Hattie Zobel
15. Birthplace: Ohio

16. Informant: Jane W. Frankenfield
Address: Rockcrest Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov 5, 1946 (month) (day) (year)
Cemetery or crematory: Wm Rutter Dumphrey Funeral Home
Location: Bethesda Md

18. Funeral director: J Gesch's Sons
Address: Hyattsville Md.

19. 11/5 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1946, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Crushed chest - hemorrhage & shock.	Sudden
Due to	
Due to	
Other conditions: Fractured facial bones; mult. f.c. of lumbar V.P.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Nov. 5, 1946
Where did injury occur? Near Largo (City or town), Pr. Geo. (County), Md. (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Aeroplane crash Injured at work? Yes

23. SIGNATURE: John J. Maloney
Address: Cheverly Md. Date signed 11-5-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

★ 11234

Reg. Dist. No. 2451

1. PLACE OF DEATH:
County: Prs Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County: Montgomery Co.
City or town: Clayton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 25 N Elmar st
(If rural, give LOCATION) ✓
2.(a) If veteran, name war:

3.(a) FULL NAME: Viola B. Freund

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles Freund
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 24. 1867

8. AGE: Years: 79 | Months: 7 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Tiffin Ohio (Town, county, and state)
10. Usual occupation: at home
11. Industry or business:
FATHER 12. Name: Russell H Slade
13. Birthplace: Belmore Ohio
MOTHER 14. Maiden name: Ann Elizabeth Bretz
15. Birthplace: Belmore Ohio
16. Informant: Russell H. Slade
Address: Hyattsville Md
17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Nov 25, 1946 (month) (day) (year)
Cemetery or crematory: Woodland Cemetery
Location: Clayton Ohio
18. Funeral director: F Gaeta sons
Address: Hyattsville Md.
19. Nov. 25 1946 (Date rec'd by registrar) Mrs. Jas. Severs (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 1946, at 9 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946, to Nov 24 1946
and that I last saw h[er] alive on 11-20 1946

Immediate cause of death	DURATION
Carcinoma of Ut	
Due to: Ulcer	1 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo A Lough M. D. or other
Address: Hyatts. Md. Date signed: 11/24/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-2450 — 1-10

11235

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 11 mos., 2 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 yrs., 11 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 - 4th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: PAULINO GASMEN.

3.(b) Social Security Number: 578-10-9513

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Filipino	Divorced

6.(b) Name of husband or wife: Rose Gasmen Calpo
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): June 20, 1910

8. AGE: Years	Months	Days	If less than one day
36	5	6	...hrs. ...min.

9. Birthplace: Narvacan, Philippine Islands
(Town, county, and state)

10. Usual occupation: Hacker

11. Industry or business

FATHER
12. Name: Tgnacio Gasmen
13. Birthplace: Philippine Islands

MOTHER
14. Maiden name: Primitiva Gasmen
15. Birthplace: Philippine Islands

16. Informant: Decedent
Address

17. (Burial, cremation, or removal. Which?) Removal
Date thereof: Nov 26 1946 (month) (day) (year)

Cemetery or crematory: -
Location: to Washington D.C.

18. Funeral director: James T. Ryan Funeral
Address: Wash, D.C.

19. (Date rec'd by registrar) Nov 26, 1946 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26th 1946, at 7:39 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24th 1943, to Nov 26th 1946
and that I last saw him alive on Nov 26th 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yr. 8 Mo
Due to: Tuberculous Cervical Adenitis	1 yr 10 Mo
Due to: Tuberculosis of Right Hip	1 yr 8 Mo
Tuberculosis of Left Hip	10 Mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 11/26/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-2430

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ 11236

Reg. Diat. No. 2300

1. PLACE OF DEATH:
County: Prince Georges Co
City or town: Rural Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos
Hospital, institution, or street address where death occurred:
Mother Joseph Rest Home
How long in hospital or institution? 11 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo
City or town: Cheverly rural Rt 4 Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emily Augusta Yeager.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: 4 March 1870
6.(c) If alive, give age ..... ysars
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
76	8		....hrs. ....min.

9. Birthplace: New York city
(Town, county, and state)
10. Usual occupation: nursing
11. Industry or business

FATHER
12. Name: Samuel Mogue
13. Birthplace: New York

MOTHER
14. Maiden name: Emily Bedell
15. Birthplace

16. Informant: Lelia Mary Burgess
Address: Bowie Rd Hyattsville Md
17. Burial Removal Date thereof: Nov 24 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location: 254 Carroll St. Takoma Park DC
18. Funeral director: D. Arthur Wallace
Address: 254 Carroll St. Takoma Park DC.
19. Nov 24th 1946 John D Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 1946, at 5:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946, to December 24 1946
and that I last saw her alive on December 17 1946

Immediate cause of death	DURATION
Chronic Myocarditis	Several years
Due to: Cerebral Edema	Several days
Due to: Senility	Several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: W. Albert Garfield M. D. or other
Address: Berwyn Md Date signed 11/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

11237

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Pr Geo Co
City or town: Colmar Manor Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr Geo Co
City or town: Colmar Manor Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3410 - 40 ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edith F Green

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Harry Green
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 20, 1880

8. AGE: Years 66 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: New York
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Wm Faulkerson
13. Birthplace: unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Harry Green
Address: Colmar Manor Md

17. Burial — Date thereof: Nov. 24, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Rural Home Cem
Location: Big Flats N Y
18. Funeral director: F. Gasch's Sons
Address: Hyattsville md

19. 11/23 1946 Amanda Downey, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 1946 at 1:45 A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to November 22 1946
and that I last saw her alive on November 21 1946

Immediate cause of death: Myocarditis with cardiac dropsy — DURATION
Due to
Due to
Other conditions: Diabetes mellitus, pyelonephritis
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: William A. Ryon, M.D.
M. D. or other
Address: 401 - Wash. N.E. - Washington D.C. — Date signed: Nov. 22 1946

VS A15 9-45-15M

1 - 35

Hd. 4000 Chambers

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2022

CERTIFICATE OF DEATH

11238

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George County
City or town: Cleverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 minutes
Hospital, Institution, or street address where death occurred: Prince Georges Gen Hosp.
How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: District Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1408 Perry St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Harris, Alice V Miss

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: 0 years

7. Birth date of deceased (mo., day, yr.): August 17, 1884

8. AGE: Years: 62 | Months: 3 | Days: 8 | If less than one day: ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER 12. Name: George W Harris
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Nora Fraley
MOTHER 15. Birthplace: Maryland

16. Informant: Brother - George Harris
Address: 5513 - Morehead Lane Bethesda

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: 11-19-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Rd. Wash. D.C.

18. Funeral director: W. W. Chambers Co.
Address: 3072 M St. N.W.

19. 11/9 1946 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1946, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Pneumonia	
Due to: Bi. Lobar bronchopneumonia	
Due to:	
Other conditions: Miliary Tuberculosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Deputy medical examiner
M. D. or other
Address: Prince Georges Co. Md. Date signed 11-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11239

CERTIFICATE OF DEATH

Reg. Diat. No. 2431

1. PLACE OF DEATH:
County: Prince George's
City or town: (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos., 26 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 612 N. St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM J. HAWKINS

3.(b) Social Security Number: 709 -12-4642

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 26, 1881

8. AGE: Years	Months	Days	If less than one day
64	10	7	hrs. min.

9. Birthplace: Charles Co., Maryland (Town, county, and state)
10. Usual occupation: Car Cleaner
11. Industry or business: Pullman Company
FATHER 12. Name: George Hawkins
13. Birthplace: Charles Co., Maryland
MOTHER 14. Maiden name: Margaret Green
15. Birthplace: Charles Co., Maryland
16. Informant: Decedent
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 6th 1946 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: D.C.
18. Funeral director: Henry S. Washington & Sons Co
Address: 467 N. St. NW Washington, D.C.
19. Nov. 2, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2 1946, at 5:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1946, to Nov. 2 1946
and that I last saw h... alive on Nov. 2 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causss, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 11/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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2 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

11240 Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George
City or town Cedar Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 years
Hospital, institution, or street address where death occurred 1003 - 62nd Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Cedar Heights (If outside city or town limits, write RURAL and give nearest town)
Street No. 1003 - 62nd Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Geneva Henderson
3.(b) Social Security Number

4. Sex Female | 5. Color or race Colored | 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Clarence E Henderson
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) February 27, 1891
8. AGE: Years 55 Months 9. Days 2 If less than one day ... hrs. ... min.
9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Henry Johnson
13. Birthplace Virginia
MOTHER 14. Maiden name ~~[illegible]~~
15. Birthplace Virginia
16. Informant Whilemina Millner
Address 18 W. Florence Ave. Wash DC
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/46 (month) (day) (year)
Cemetery or crematory Harmony Cemetery
Location Washington DC
18. Funeral director Henry S. Washington & Sons
Address 467 N St. N.W.
19. Dec. 1 1946 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1946, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....
and that I last saw h.... alive on .... 19....

	DURATION
Immediate cause of death Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations .... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?
Deputy medical Examiner
23. SIGNATURE James R. Lord M. D. or other
Address Hyattsville Md Date signed 11-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

11241

Reg. Dist. No. 2450

1. PLACE OF DEATH:
County: Prince George County
City or town: Greenbelt, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9
Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hosp.
How long in hospital or institution? 9

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Hendron Miss Anne Louise

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 21, 1861

8. AGE: Years	Months	Days	If less than one day
85	8		hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: William Thomas Hendron
13. Birthplace: Norfolk, Virginia

MOTHER
14. Maiden name: Mrs. Fanitte Vaughan
15. Birthplace: Virginia

16. Informant: Leland Memorial Hospital Record
Address: Riverdale, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 23-46 (month) (day) (year)
Cemetery or crematory: Mowaco
Location: Beelsville, Md.
18. Funeral director: William B. Dillon
Address: Barnesville, Md.

19. 11/21 1946 (Date rec'd by registrar) Amanda Deaver, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1946, at 2 10 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18 1946, to Nov. 21 1946
and that I last saw h.. alive on Nov. 20 1946

	DURATION
Immediate cause of death: Arteriosclerotic heart disease	
Due to: Generalized arteriosclerosis	
Due to:	
Other conditions: Pernicious Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Rowland F. Workman M.D.
M. D. or other
Address: Leland Memorial Hospital Riverdale, Md. Date signed 11-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

11242

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 435 Ridge St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: LEO HULETT

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9, 1927

8. AGE: Years	Months	Days	If less than one day
19	5	29	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Helper on truck

11. Industry or business:

FATHER
12. Name: Delward Hulett
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Washington, D. C.

16. Informant: Decedent

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Nov. 7, 1946 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Henry S. Washington & Son

Address: 467 N St. N.W.

19. Nov. 7, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7, 1946, at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 22, 1946, to Nov. 7, 1946, and that I last saw h.. alive on Nov. 6, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 11/7/46

2-25

2-2430 ——— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 11243

Reg. Diat. No. 2420

1. PLACE OF DEATH:

County Prince Georges

City or town Bowie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Moment

Hospital, institution, or street address where death occurred:

Race track

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Monkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Bosley Hutchins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1886

8. AGE: Years 60 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name William Hutchins

13. Birthplace Maryland

MOTHER 14. Maiden name Laura Bosley

15. Birthplace Maryland

16. Informant William Hutchins

Address Monkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 2, 1946 (month) (day) (year)

Cemetery or crematory St James Cemetery

Location Monkton Md

18. Funeral director E. Gasche's sons

Address Ayattsville Md.

19. 11/28 (Date rec'd by registrar) 1946 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1946, at 2 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy Medical Examiner Samuel D. Ford M.D. or other

Address Forestville Md Date signed 11-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9820

CERTIFICATE OF DEATH

★ 11244

Reg. Dist. No. 2320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: Naylor - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs
Hospital, institution, or street address where death occurred: none
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George's
City or town: Naylor - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Benjamin Wear Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of ~~husband~~ or wife: Mary E. Johnson
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): November 25 1864

8. AGE:

Years	Months	Days	If less than one day
82	0	4	....hrs. ....min.

9. Birthplace: Naylor - Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm

FATHER
12. Name: Benjamin Johnson
13. Birthplace: Va

MOTHER
14. Maiden name: Ella Driggs
15. Birthplace: Md

16. Informant: Benjamin M. Johnson
Address: Croom Station - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 2 1946 (month) (day) (year)
Cemetery or crematory: Brooke's Cem
Location: Naylor's, Md
18. Funeral director: C. E. Johnson
Address: Upper Marlboro, Md.
19. Dec 2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1946 at 12:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from About 3 1946 to Nov 29 1946
and that I last saw him alive on Nov 29 1946

	DURATION
Immediate cause of death: Congestive Heart Failure	2 months
Due to: Auricular Fibrillation	2 yrs
Due to: Myocarditis	2 yrs
Other conditions: Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James E. Tasker M. D. or other
Address: Upper Marlboro Date signed 11-29-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87d

CERTIFICATE OF DEATH

11245

Reg. Diat. No. 245 1

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. Rt. 3. P. O. Box 723
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elinor D. Karsten

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1872

8. AGE: Years 74 | Months 11 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Indianapolis, Indiana
(Town, county, and state)

10. Usual occupation Social worker & Author

11. Industry or business

FATHER 12. Name Robert P. Daggett

13. Birthplace New Haven, Conn.

MOTHER 14. Maiden name Eliza Frost

15. Birthplace New Haven Conn.

16. Informant Karl Karsten (son) R.3

Address Bethesda, Md. Rt. 3. P.O. Box

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov 2 1946 (month) (day) (year)

Cemetery or crematory

Location Bethesda Md.

18. Funeral director Wm. B. Sanders

Address Bethesda Md.

19. Nov. 2 1946 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st 1946, at 4:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 1946 to Nov. 1 1946 and that I last saw h.e.r. alive on Nov. 1. at a.m. 1946

Immediate cause of death Arteriosclerotic heart decease — DURATION: after 8 days

Due to Multiple sclerosis

Due to Generalized arteriosclerosis — DURATION: 25 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Maben M.D.
M. D. or other

Address Riverdale Md. Date signed 11-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-24

2-2450

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

11246

Reg. Dist. No. 234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: PRINCE GEORGE

City or town: SILVER HILL, MD. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 204 PARK BLVD SE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: PRINCE GEORGE

City or town: SILVER HILL MD (If outside city or town limits, write RURAL and give nearest town)

Street No. 204 PARK, BLVD SE (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ELIZABETH ANN KELLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	

B.(b) Name of husband or wife: LOUIS P KELLER

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): SEPT. 19, 1878

8. AGE: Years	Months	Days	If less than one day
68	2	11	hrs. min.

9. Birthplace: BAILEY'S CROSSROADS, VA. (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER 12. Name: GEORGE HEAD

13. Birthplace: VIRGINIA

MOTHER 14. Maiden name: MARY A RILEY

15. Birthplace: BALTIMORE, MD.

16. Informant: ELIZABETH K MINTERS

Address: 204 PARK BLVD. SILVER HILL MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof NOV. 27-46 (month) (day) (year)

Cemetery or crematory: ST JAMES CATHOLIC

Location: FALLS CHURCH, VIRGINIA

18. Funeral director: Joseph Gawler's Sons Inc

Address: 1756 Penna Ave, N.W. Washington DC

19. NOV 25 1946 (Date rec'd by registrar) Howard J Brack Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 1946 at 5 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 1944, to Nov 24 1946 and that I last saw her alive on November 23 1946

Immediate cause of death	DURATION
Carcinoma of breast	2½ years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James C Conrad M.D. M. D. or other

Address: 2522 Pa. Ave. S.E. Washington, DC Date signed 11/24/46

2-25

2 - 2340 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-a

CERTIFICATE OF DEATH

11247

Reg. Diat. No. 2451

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 YEARS
Hospital, institution, or street address where death occurred:
SACRED HEART HOME
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME PETER JOHN KIRCHNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife KATRHAN BOSHER
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 24, 1864

8. AGE: Years	Months	Days	If less than one day
80	8	16	hrs. min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual occupation BAKER
11. Industry or business

FATHER
12. Name JACOB KIRCHNER
13. Birthplace GERMANY

MOTHER
14. Maiden name VERCINC STENGER
15. Birthplace GERMANY

16. Informant HOSP.
Address SACRED HEART HOME.

17. removal (Burial, cremation, or removal. Which?) Date thereof Nov 11, 1946 (month) (day) (year)
Cemetery or crematory Columbia Gardens
Location Arlington, Va.
18. Funeral director Walter E. Fitzgerald
Address 3245 Wilson Blvd. Arl. Va.

19. Nov. 8 19 46 Mrs. Jas. Sevens (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 19 46, at 7:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 45, to Nov. 8 19 46
and that I last saw h.. alive on Nov 8, 19 46

Immediate cause of death Toxic myocarditis — DURATION 3 mos.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank R. Shea M.D. M. D. or other
Address 4100 - 22nd St. N Date signed 11/9/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-2 450

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11248

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 Yrs; 9 Mi; 20 D
Hospital, Institution, or street address where death occurred: Laurel Sanitarium
How long in hospital or institution? 13 Yr; 9 Mi; 20 D

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2250 Linden Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3. (a) FULL NAME: Emma Lion

3. (b) Social Security Number: .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 4 - 1866

8. AGE: Years 80 | Months 10 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: .....

FATHER
12. Name: Elkin Lion
13. Birthplace: Germany

MOTHER
14. Maiden name: Hannah Oldfelter
15. Birthplace: Germany

16. Informant: Sanitarium Records
Address: Laurel San. ; Laurel, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 12/1/46
(month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Balto. Md.

18. Funeral director: Harold Sandstrom & Son
Address: 1907 Eutaw Place.

19. 11/30 1946
(Date rec'd by registrar)
A. W. Hauck
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1946, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1936, to Nov. 29 1946
and that I last saw h[illegible] alive on November 29 1946

Immediate cause of death: Cardiac decompensation — DURATION: 3 Days
Due to: General Arteriosclerosis — 10 yrs
Due to: Senility
Other conditions: .....
(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John L. Wetherell M.D.
M. D. or other
Address: Laurel Sanitarium, Laurel, Md. Date signed 11/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ 11249

Reg. Dist. No. 2340

1. PLACE OF DEATH:
County: Prince Georges
City or town: Clinton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr Georges
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Temple Hills Road.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Susie Lyles

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	colored	Widowed

6.(b) Name of husband or wife: Frank Lyles
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1861 "July" unknown

8. AGE: Years 85 Months about Days If less than one day: age unknown

9. Birthplace: St Marys Co. Md.
(Town, county, and state)

10. Usual occupation: Domestic.

11. Industry or business: Own Home.

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Delie Halley
15. Birthplace: St Marys Co Md

16. Informant: James Robert Lyles
Address: Clinton Md. (Son)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27 1946 (month) (day) (year)
Cemetery or crematory:
Location: T. B., Md.

18. Funeral director: Barnes & Matthews
Address: 614-4½ St. S.W. Wash. 4, DC

19. Nov. 25 1946 (Date rec'd by registrar) Mrs. Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 25 1946, at 2A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17 1946, to Nov 25 1946
and that I last saw her alive on Nov 23 1946

Immediate cause of death	DURATION
acute myocardial failure	1 hr.
Due to Cardio Vascular Renal Disease	unknown
Due to General Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: no Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work? —

23. SIGNATURE: Rene C Van Hatten M. D. or Coroner
Address: Washington 12 DC Date signed: Nov 25 1946

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 11250

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 20 days.

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 10 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4934 1st St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WALTER T. MAGUIRE

3.(b) Social Security Number: 577-14-4969

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: Alma Vinton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 27, 1910

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
36	8	0		

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Interior Decorator

11. Industry or business:

FATHER
12. Name: Frank Maguire
13. Birthplace: Ireland

MOTHER
14. Maiden name: Elizabeth Schrider
15. Birthplace: Silver Spring, Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-30-46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington, D. C.

18. Funeral director: F. Gasch & Sons
Address: Hyattsville, Md.

19. Nov. 27, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27, 1946, at 4:47 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8, 1946, to Nov 27, 1946 and that I last saw him alive on Nov 27, 1946.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	6 3 Mo
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 11/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-2430

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

11251

Reg. Dist. No. 242

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Prince Georges

City or town: Lanham (rural Sheriff Rd)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Lanham (rural Sheriff Rd)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Charles Mangold

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie Elizabeth Hagle Mangold

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): July 1, 1869

8. AGE:

Years	Months	Days	If less than one day
77	4	24	...hrs. ...min.

9. Birthplace: Ind. near Indiana
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Home building

FATHER
12. Name: Martin Edward Mangold
13. Birthplace: Germany

MOTHER
14. Maiden name: Christina
15. Birthplace: Charles Co. Maryland

16. Informant: Annie E. K. Mangold
Address: Lanham Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 29, 1946 (month) (day) (year)

Cemetery or crematory: Ft Lincoln

Location: Colmar Manor Md

18. Funeral director: F. Gaeths sons

Address: Hyattsville Md.

19. 11/29 (Date rec'd by registrar) 19 46 Amanda Downey Registrar

11/30/46 - Mrs. Jack Bennette O.L.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1946 to Nov 25 1946 and that I last saw h... alive on November 25 1946

Immediate cause of death	DURATION
Acute Myocarditis	1 day
Due to: Hypertension	3 years
Due to:	
Other conditions: Cerebral haemorrhage	1 1/4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Robert S McEnery M.D.
M.D. or other

Address: 402 Main St Laurel Md ...Date signed: 11/25/46

2-125

2-2420-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-d

11252

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1.-PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 11 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 2 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington, D. C. (If outside city or town limits, write RURAL and give nearest town)

Street No. 1412 Chapin St., N. W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH E. McGOLRICH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen J. McGolrick

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1884

8. AGE: Years	Months	Days	If less than one day
61	10	22	hrs. min.

9. Birthplace: Brooklyn, New York (Town, county, and state)

10. Usual occupation: Assistant Director, Permit Bureau

11. Industry or business: D. C. Health Department

FATHER — 12. Name: James J. McGolrick

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary E. McCauley

MOTHER — 15. Birthplace: Ireland

18. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 25, 1946 (month) (day) (year)

Cemetery or crematory: Washington National Park Cemetery

Location: Suitland, Prince George's Co., Md.

18. Funeral director: R. W. Chambers Co.

Address: 1400 Chapin St. N.W.

19. Nov. 20, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20 1946, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9, 1946, to Nov. 20, 1946

and that I last saw him alive on Nov. 20, 1946

Immediate cause of death	DURATION
Carcinoma of Right Lung	4½ Mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Bronchogenic carcinoma of right lung,

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 11/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430

2-10

11253

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 25 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 517 7th. St., S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DOROTHY MOY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Chinese	Married

6.(b) Name of husband or wife: Carter Moy
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): 10/10/22

8. AGE: Years	Months	Days	If less than one day
24	1	9	..... hrs. ..... min.

9. Birthplace: Canton, China (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: --

FATHER
12. Name: You Moy
13. Birthplace: California

MOTHER
14. Maiden name: Unknown
15. Birthplace: China

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 23, 1946 (month) (day) (year)
Cemetery or crematory: George Washington Memorial Cem.
Location: Prince George's Co., Md.

18. Funeral director: W W Chambers Co
Address: 1400 Clifton St NW

19. Nov. 19, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 19, 1946, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25, 1946, to Nov. 19, 1946, and that I last saw h.er alive on Nov. 19, 1946.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	9 mo.
Due to: Tuberculous Laryngitis	4 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md Date signed: 11/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-2

2-2430

2-10

11254

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ Reg. Dist. No. 2451

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 MO
Hospital, institution, or street address where death occurred:
5406 - 15TH AVE.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGE
City or town HYATTSVILLE, ~~Md.~~
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5406 - 15TH AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME FREDERICK WALDRON NEWELL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife PEARL
6.(c) If alive, give age ——— years
7. Birth date of deceased (mo., day, yr.) FEB 21, 1870

8. AGE: Years	Months	Days	If less than one day
76			...hrs. ...min.

9. Birthplace TROY PENNA. (Town, county, and state)
10. Usual occupation CARPENTER
11. Industry or business BUILDING
FATHER 12. Name DANIEL C. NEWELL
13. Birthplace PENNA
MOTHER 14. Maiden name UNKNOWN
15. Birthplace " "
16. Informant HOWARD F NEWELL
Address 5406-15th Ave HYATTSVILLE MD.
17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 11/23/46 (month) (day) (year)
Cemetery or crematory
Location 2525 - Bladensburg Rd N.E. DC
18. Funeral director Gilbert C. Prescott
Address 2525 Bladensburg Rd N.E.
19. Nov 23 1946 (Date rec'd by registrar) [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1946, at 4:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/30 1946, to 11/23 1946 and that I last saw him alive on 11/20 1946

	DURATION
Immediate cause of death: Exhaustion	2 mos
Due to: Pulmonary Tuberculosis	3 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: 0
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. W. Conklin M.D. M. D. or other
Address 3100 - 20 NE DC Date signed 11/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-25

2-2450- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

★ 11255 Reg. Dist. No. 245

1. PLACE OF DEATH:
County Pro Geo Co
City or town College Park Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years - 7 months
Hospital, institution, or street address (where death occurred): —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pro Geo Co
City or town College Park Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4615 Harvard Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Susan Elizabeth Pear.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 26. 1943.

8. AGE: Years 3 | Months 6 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Charles B. Pear Jr.
FATHER 13. Birthplace Mass.

MOTHER 14. Maiden name Ada Benning
MOTHER 15. Birthplace Glenville N. J.

16. Informant Charles B. Pear
Address College Park Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Nov 23. 1946 (month) (day) (year)
Cemetery or crematory Linwood Cemetery
Location Westerm, Mass

18. Funeral director F. Busch's sons
Address Hyattsville Md.

19. Nov 23 1946 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23, 1946, at 1.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 1946 to Nov. 23 1946
and that I last saw h[illegible] alive on November 22 1946

Immediate cause of death	DURATION
Acute lymphatic leukemia	1 mo
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Louis Mendel, M.D. M. D. or other
Address College Park, Md. Date signed 11/23/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

11256

CERTIFICATE OF DEATH

Reg. Dist. No. 2420

1. PLACE OF DEATH:

County PRINCE GEORGE

City or town SUITLAND — (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 MO.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGE

City or town SUITLAND. (If outside city or town limits, write RURAL and give nearest town)

Street No. 4349 - SPRING ST (If rural, give LOCATION)

2.(a) If veteran, name war NONE

3.(a) FULL NAME LOUTIE Lee PIPER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	WHITE	WIDOW

6.(b) Name of husband or wife JOHN W PIPER (DECEASED) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 8 - 1862

8. AGE: Years 84 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace ARROW ROCK - MO. (Town, county, and state)

10. Usual occupation NONE

11. Industry or business NONE

FATHER 12. Name LITTLETON D LINDSAY

13. Birthplace VA.

MOTHER 14. Maiden name MARY F. BROWN

15. Birthplace MO

16. Informant ELIZABETH L DAVIS

Address 4349 - SPRING ST. SUITLAND - MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-25-46 (month) (day) (year)

Cemetery or crematory Rock Arrow Hood, Mo.

Location

18. Funeral director W. W. CHAMBERS CO.

Address 517-11TH ST S.E. WASH. D.C.

19. Nov. 22 1946 (Date rec'd by registrar) Carrie F. Campbell (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 November 1946, at 12 20 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 November 1946 to Present 21 Nov. 1946 and that I last saw h.e.r. alive on 20 November 1946

Immediate cause of death	DURATION
Broncho-pneumonia	4 days
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sidney W. Emery M.D.

Address 1503 Good Hope Rd. S.E. M. D. or other Date signed 21 Nov. 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83€)

CERTIFICATE OF DEATH

A257

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Geo. Co.
City or town Wildercroft
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. Geo - Hosp
City or town Wildercroft
(If outside city or town limits, write RURAL and give nearest town)
Street No. Good Luck Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Clyde A Port

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Ida Port
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) March-13-1867

8. AGE: Years	Months	Days	If less than one day
79			hrs. min.

9. Birthplace Tyron Pa (Town, county, and state)
10. Usual occupation Salesman "retired"
11. Industry or business

FATHER
12. Name Wm Port
13. Birthplace Pa

MOTHER
14. Maiden name Anna Espley
15. Birthplace Pa

18. Informant Ida Port
Address Good Luck Rd. Wildercroft, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16-46 (month) (day) (year)
Cemetery or crematory Nath. Cap. Mem. Pk. County
Location Muirkirk, md
18. Funeral director Lee Chandler Co
Address Riverdale md

19. Nov 16 1946 (Date rec'd by registrar) Mrs Jas. Devera Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-13- 1946, at 8 50 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13 1939, to Nov. 13 1946 and that I last saw him alive on Nov 12 1946.

	DURATION
Immediate cause of death Cerebral Thrombosis	7 years
Due to General Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. W. Mahan MD
M. D. or other
Address Riverdale Md. Date signed Nov. 14, 1946

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-2450

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

11258

Reg. Dist. No. 2320

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Clinton Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Oct 1909

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo Co.

City or town Clinton, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Jenkins Corner

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mary Ida Proctor

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Negro	married

6.(b) Name of husband or wife Josiah Proctor

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Oct 25 1895

8. AGE:

Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business at Home

FATHER

12. Name unknown

13. Birthplace —

MOTHER

14. Maiden name Agnes Brown

15. Birthplace Prince Georges Co Md.

16. Informant Fred Proctor

Address Clinton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11-14-46 (month) (day) (year)

Cemetery or crematory —

Location Washington D.C.

18. Funeral director W. E. Bowie Harris Co.

Address 1432 You St. N.W. Washington D.C.

19. Nov 14 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1946 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1946, to Nov 14 1946

and that I last saw her alive on Nov 13 1946

Immediate cause of death	DURATION
Acute Coronary Thrombosis	1 hr
Due to General arteriosclerosis with Myocarditis	many yrs
Due to High blood pressure	many yrs
Other conditions None of note	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. .....

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury — Injured at work? —

23. SIGNATURE Paul C. Von Matta M. D. or Other

Address Washington 19 DC Date signed Nov 14 1946

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11259

Reg. Dist. No. 2451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George

City or town: Mount Rainier (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Pr. Geo.

City or town: Mt Rainier, Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 3206 - Varnum St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ernest Chas Prusser

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Grace M. Prusser

6.(c) If alive, give age: 50? years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1875 (Nov. 11, 1875)

8. AGE: Years	Months	Days	If less than one day
70	11	9	hrs. min.

9. Birthplace: Easton, Pa. (Town, county, and state)

10. Usual occupation: Retired Cabinet Maker

11. Industry or business

FATHER 12. Name: Richard F. Prusser

13. Birthplace: Germany

MOTHER 14. Maiden name: Margaret Stout

15. Birthplace: Germany

16. Informant: Fredrick Chas Prusser

Address: 3417 - Tilden St., Brentwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 7. 1946. (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington D.C.

18. Funeral director: F. Gusche & Sons

Address: Hyattsville Md

19. Nov. 7 1946 (Date rec'd by registrar) Mrs. Jos. Devere Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5 1946, at 4 A. M.?

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death	
Intrapulmonary hem -	Sudden
Due to: carriage -	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John W. Maloney M.D. acting Deputy Md. Examiner M. D. or other

Address: Cheverly, Md Date signed 11-6-46

2-25

2 - 2450 ——— 2-10

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

11260

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1186 Morris St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Wm J. RAWLINGS

3. (b) Social Security Number: 579-01-3120

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. Rawlings
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): September 9, 1892

8. AGE: Years	Months	Days	If less than one day
54	1	23	...hrs. ...min.

9. Birthplace: Upper Marlboro, Maryland (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business:

FATHER
12. Name: James Rawlings
13. Birthplace: Nottingham, Maryland

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Nottingham, Maryland

16. Informant: Decedent
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-4-46 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Upper Marlboro Md
18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md

19. Nov 1 46 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1st 1946, at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3rd 1946, to Nov 1st 1946
and that I last saw him alive on Nov 1st 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md Date signed: 11/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-2430 _____ 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11261

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 Myrtle St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: MARY ANN ROBERTSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (separated)

6.(b) Name of husband or wife: Homer Robertson

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 11, 1897

8. AGE: Years	Months	Days	If less than one day
49	4	13	...hrs. ...min.

9. Birthplace: Augusta, Georgia
(Town, county, and state)

10. Usual occupation: Maid

11. Industry or business:

FATHER
12. Name: George Kelly
13. Birthplace: Georgia

MOTHER
14. Maiden name: Amanda Thomas
15. Birthplace: Georgia

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof 11/25/46 (month) (day) (year)
Cemetery or crematory: Woodland Cemetery
Location: to Wash. D.C.

18. Funeral director: Watson Funeral Home
Address: 909 Pennsylvania Ave. S.W.

19. Nov. 24, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 24 1946, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 13 1946, to NOVEMBER 24 1946 and that I last saw h. alive on Nov. 24 1946

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	8 mos
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D., M. D. or other
Address: Glenn Dale, Md. Date signed: Nov. 24, '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430 2-10

11262

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 1104 42nd St., S. E. (If rural, give LOCATION)
2.(a) If veteran, name war: First World War

3.(a) FULL NAME: NATHANIEL ROYALL

3.(b) Social Security Number: 081-22-3980

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ellen Royall
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): November 28, 1896

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
50	0	2		

9. Birthplace: Clinton, North Carolina (Town, county, and state)
10. Usual occupation: teacher
11. Industry or business:
FATHER — 12. Name: Nathaniel Royall; 13. Birthplace: Clinton, North Carolina
MOTHER — 14. Maiden name: Rachel Royall; 15. Birthplace: Clinton, North Carolina
16. Informant: Deceased
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 2, 1946 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: John T. Hines & Co.
Address: 901-3 & 5th St. SW Wash. D.C.
19. Nov. 30, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30, 1946, at 8:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 5, 1946, to Nov 30, 1946, and that I last saw him alive on Nov 30, 1946.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 MO.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 11/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11263

Reg. Dist. No. 2391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: RURAL, LAUREL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred: Mrs. Mary Davis Nursing Home
How long in hospital or institution? 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ~~42~~ 42 Lawrence Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME RUTH ANN RUTHERFORD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	S

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1941

8. AGE:

Years	Months	Days	If less than one day
5	2	3	..... hrs. ..... min.

9. Birthplace: Takoma Park, Montgomery County, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Edward Oscar Rutherford
13. Birthplace: Westernport, Maryland

MOTHER
14. Maiden name: Ruth Elizabeth Thomas
15. Birthplace: Takoma Park, Maryland

16. Informant: Edward Oscar Rutherford
Address: 42 Lawrence Ave, Kensington, Md

17. Burial (Burial, cremation, or removal) Date thereof Nov. 16 1946 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: Wilmer E. Humphrey
Address: Silver Spring, Md.

19. 11-13 1946 Clara E. Webster Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13 1946 at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/28 1946 to 11/13 1946 and that I last saw her alive on 11/11 1946

	DURATION
Immediate cause of death: Bronchopneumonia, Bilateral	1 week
Due to: Infection	
Due to:	
Other conditions: Bilateral spastic paralysis, Cause undetermined	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John Stephens M.D.
M. D. or other
Address: Laurel, Maryland Date signed 11/13/46

2-25

2-2390

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (956)

CERTIFICATE OF DEATH

11264 2230

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges.
City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs - 4 mos
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George.
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1312 Oakton Drive.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harold Lee Simmers.

3.(b) Social Security Number: 578-07-1371

4. Sex: Male.
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Thelma Henrietta Simmers
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct 28, 1907
8. AGE: Years: 39 | Months: 0 | Days: 6 | If less than one day: ..... hrs. ..... min.
9. Birthplace: Harrisonburg Va.
(Town, county, and state)
10. Usual occupation: Caretaker & Agent.
11. Industry or business: Fries Bead & Chain Co.
FATHER 12. Name: Harvey L Simmers
13. Birthplace: VIRGINIA.
MOTHER 14. Maiden name: DORA L. ENSMINGER
15. Birthplace: VIRGINIA.
16. Informant: Mrs. Thelma H. Simmers
Address: 1312 Oakton Dr, Takoma Park Md
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: Nov. 6 - 1946 (month) (day) (year)
Cemetery or crematory: ROCK CREEK.
Location: WASHINGTON - D.C.
18. Funeral director: Warner E. Pumphrey
Address: SILVER SPRING - MD
19. Nov 7 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 4 1946, at 12 15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1945, to Nov 4 1946
and that I last saw him alive on Nov 3 1946.

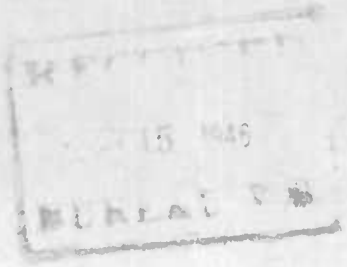
	DURATION
Immediate cause of death: Rheum Heart Disease.	
Due to: Decompensation	from 12/3/45.
Due to: Fatty Liver	since last 1945
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Howard L Morse. M.D.
M. D. or other
Address: 28 Carroll Ave Takoma Park Md Date signed 11/4/46



2-35

Evidence for correction of name of deceased, father's name and mother's birthplace shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)a

11265

FILM No. G 110 JUN 11 1947 **CERTIFICATE OF DEATH**

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince Georges
City or town Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
Harris Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince Georges
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Arthur Herbert Simpson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Elizabeth Kelly Simpson
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) October 24, 1876

8. AGE: Years	Months	Days	If less than one day
70	0	22	hrs. min.

9. Birthplace Mitchellville Pri. Ge. C. Maryland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER 12. Name George Thomas Simpson
13. Birthplace Mitchellville, Md

MOTHER 14. Maiden name Mary Ann Kegle
15. Birthplace ~~England~~ Washington, D. C.

18. Informant James Arthur Simpson
Address Mitchellville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/19/1946 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cemetery
Location District Line — Maryland
18. Funeral director Ritchie Brothers
Address Upper Marlboro

19. Nov 16 1946 M. Brashears Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 16 1946, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 2 1946, to 11 16 1946
and that I last saw him alive on 11 16 1946

Immediate cause of death	DURATION
Coronary Cardio Renal dis.	2 yr.
Due to Secondary anemia	1 yr.
Due to Gen. Arteriosclerosis	2 yr.
Other conditions Hypostatic Pneumonia	10 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B P Warren M. D. or other
Address Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11266

★ Reg. Dist. No. 2320

1. PLACE OF DEATH:
County: Prince George
City or town: Croom Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Croom Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William H. Smith

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 4-41

8. AGE: Years 5 | Months 3 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Croom, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Wendell E. Smith
13. Birthplace Croom, Md.

MOTHER 14. Maiden name Ethel Jones
15. Birthplace Washington, D.C.

16. Informant Wendell E. Smith
Address Croom, Md.

17. Burial — Date thereof 11-25-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's
Location Croom, Md.

18. Funeral director Ritchie Brothers
Address Upper Marlboro, Md.

19. NOV 25 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Nov 1946, at 11 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Nov 1946, to 23 Nov 1946 and that I last saw h.i.m. alive on 23 Nov 46 1946

Immediate cause of death	DURATION
Tuberculosis, pulmonary, acute bilateral	6 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert B. Lasser M.D.
M. D. or other
Address Upper Marlboro, Md. Date signed 24 Nov 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State: Md County:
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 12 - C St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Dora Snyder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Sol Isaac
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): Feb 28 - 1892

8. AGE: Years	Months	Days	If less than one day
54	8	13	..... hrs. ..... min.

9. Birthplace: Warsaw Poland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Harry Meyer Frankel
13. Birthplace: Poland
MOTHER 14. Maiden name: Anna Greenberg
15. Birthplace: Poland
16. Informant: Hospital records
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-12-46 (month) (day) (year)
Cemetery or crematory: Wash Blvd
Location: Wash Blvd
18. Funeral director: Jack Leura Inc
Address: 1439 E. Balto St
19. Nov 11 1946 (Date rec'd by registrar) P.W. Hedrick Registrar
1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10 - 1946 at 10:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/7- 1944, to 11/10 1946
and that I last saw h- alive on 11-10 1946.

	DURATION
Immediate cause of death: Pulmonary Infarct.	1 min.
Due to: Coronary occlusion	2 hrs
Due to: Diabetes	9 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M. B Frankel M. D. or other
Address: 352 B. Ga Ave Laurel Md. Date signed: 11/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

11268

★ Reg. Dist. No. 3420

1. PLACE OF DEATH:
County: Prince Georges
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7100 - Sheriff Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Katie Sally Spriggs

3.(b) Social Security Number: 579-16-1208

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Walter Spriggs
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Feb 14, 1899

8. AGE: Years	Months	Days	If less than one day
47	9	24	hrs. 15 min.

9. Birthplace: Upper Marlboro (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles Green
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lottie Green
15. Birthplace: Maryland

16. Informant: Daughter & Husband
Address: Seat Pleasant

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 21, 46 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
16. Funeral director: Henry S. Washington & Sons
Address: 467 N St. N.W. Wash. D.C.

19. Nov. 21 19 46 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21st 19 46, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9th 19 46, to Nov 20th 19 46
and that I last saw h.er alive on Nov. 20th 19 46

Immediate cause of death	DURATION
Hypostatic Pneumonia	24 hrs.
Due to: Cardiac Decompensation	2 Wks
Due to: Arteriosclerosis	indet.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John W. Rout, M.D. M. D. or other
Address: 515 - Eastern Ave. Date signed: 11-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (469)

CERTIFICATE OF DEATH

(X) 11269

Reg. Dist. No. 2451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prs Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years.
Hospital, Institution, or street address where death occurred:
Belview Farms
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prs Geo Co.
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Belview Farm
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Sturzenegger :-

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) unknown 1881

8. AGE: Years	Months	Days	If less than one day
65			hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Laborer – Farm –

11. Industry or business

FATHER 12. Name: unknown

FATHER 13. Birthplace: unknown

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace: unknown

16. Informant: Louis Sturzenegger
Address: Belview Farm - Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 16 1946 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington D.C.

18. Funeral director: F. Gaeta & Sons
Address: Hyattsville Md.

19. Nov 15 1946 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14, 1946, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to Carcinoma of head & pancreas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Deputy Medical Examiner M.D. or other
Address: Hyattsville Md Date signed 11-14-46

1-21

2-2450

1-10

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

11270

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George's
City or town: Near Largo - Transit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4506 Woodbury St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II (S)

3.(a) FULL NAME: Frank Eugene Tate

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mayoie Tate.
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): April 19-1921.

8. AGE: Years: 25. Months: 6. Days: 16. If less than one day: hrs. min.

9. Birthplace: Los Angeles, Cal.
(Town, county, and state)

10. Usual occupation: Mechanic
11. Industry or business: Airplane

FATHER
12. Name: Walter E. Tate
13. Birthplace: York, Pa.

MOTHER
14. Maiden name: Ruth Kent
15. Birthplace: Kansas

16. Informant: Mayoie Tate
Address: 4506 Woodbury St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 7, 1946. (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington Va

18. Funeral director: F. Gaeth & Sons
Address: Hyattsville Md.

19. 11/6 (Date rec'd by registrar) 1946 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 5 1946, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Multiple fractures of head, chest and body	Sudden
Due to: Hemorrhage & shock	
Due to:	
Other conditions: Multiple lacerations of skin & muscles	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Nov 5, 1946
Where did injury occur? Near Largo (City or town) Pr. Geo (County) Md (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Airplane crash Injured at work? Yes

23. SIGNATURE: John D. Maloney M.D.
acting Asst. Med. Examiner M. D. or other
Address: Riverdale, Hyattsville Md. Date signed: 11-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11271

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 8 mos., 12 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 8 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2313 - L. St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: JAMES TAYLOR

3. (b) Social Security Number: 578-09-9684

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Dorothy Taylor

6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): January 23, 1911

8. AGE: Years	Months	Days	If less than one day
35	9	20	...hrs. ...min.

8. Birthplace: Germantown, Maryland
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: Moriah Clinton

15. Birthplace: Germantown, Maryland

16. Informant: Decedent

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Nov 12, 1946 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Chapin Funeral Home Inc

Address: 389 - R I ave nw

19. Nov. 12, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 12 1946, at 12:35 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from MAR. 31, 1944, to NOV. 12, 1946

and that I last saw h.i.m. alive on NOV. 12, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yr. 8 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Nov. 12, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2 - 2

2 - 2430

2 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

11272

Reg. Dist. No. 2391

1. PLACE OF DEATH: County: P. Geo

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: P. Geo

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 624 - 9th St

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Philip Thomas 5 20

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: —

6.(b) Name of husband or wife: —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept 24-46

8. AGE: Years — Months: 2 — Days: 2 — If less than one day: ... hrs. ... min.

9. Birthplace: Laurel P G md
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: —

FATHER
12. Name: Wilburn Thomas
13. Birthplace: Laurel Md

MOTHER
14. Maiden name: Bernice Hall
15. Birthplace: Howard Co Md

16. Informant: Bernice Thomas
Address: 618 9th St Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 28 1946 (month) (day) (year)

Cemetery or crematory: Bacon Cemetery

Location: Near Laurel Md

18. Funeral director: Ridgely & Selby

Address: 401 Main Ave Laurel Md

19. 11-27 1946 (Date rec'd by registrar) Cora E. Wacketer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26. 1946 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 1946 to Nov 26 1946

and that I last saw h... alive on Nov 26 1946.

Immediate cause of death: Patent Ductus Arteriosus — DURATION: 2 yr.

Due to: Patent Ductus arteriosus

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: W. B. Jandrow M. D. or other

Address: Laurel Md Date signed: 11/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-2

2-2090

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

* 11273

Reg. Dist. No. 2421

1. PLACE OF DEATH:
County: Prince George County
City or town: Oaklawn, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo. County
City or town: Oaklawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7371 Allentown Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JOSEPH K. THREN

3. (b) Social Security Number: 4-204-190

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maria M.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 9, 1874

8. AGE: Years	Months	Days	If less than one day
72	5		..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Motorman
11. Industry or business: Capital Traction Co.
FATHER 12. Name: Marx Sim Thren
13. Birthplace: Germany
MOTHER 14. Maiden name: Katerine Albrich
15. Birthplace: Germany
16. Informant: Franz X. Schumm
Address: 1320 D Street, S.E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 11, '46 (month) (day) (year)
Cemetery or crematory: Saint Mary's Cemetery
Location: Washington, D.C.
18. Funeral director: James A. Ryan, Inc.
Address: 317 Pennsylvania Ave., S.E.
19. 11-8-46 (Date rec'd by registrar) 19 Thos. O. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8, 1946, at 2:30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1945, to Nov 8, 1946 and that I last saw h.. alive on Nov 7, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Coma.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. Lott G. Lucky, M. D. or other
Address: 621 Md Ave NE Date signed: Nov 8, 1946.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

2-25

2-2420

2-16

Evidence for the city of birthdate is [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

FILE No. I 08 NOV 26 1946

★ 11274

Reg. Dist. No. 245

1. PLACE OF DEATH:
County 6300 Sheriff Rd NE
City or town Fairmount Hts. (If outside city or town limits, write RURAL and give nearest town) Md.
How long in above place of death? 7 yrs.
Hospital, Institution, or street address where death occurred: 6300 Sheriff Rd NE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges
City or town Fairmt Hts Md (If outside city or town limits, write RURAL and give nearest town)
Street No. 6300 Sheriff Road. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John E. Gramble

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898 ~~1895~~

8. AGE: Years 98 | Months | Days | If less than one day hrs. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden name unknown
15. Birthplace

18. Informant John W. Dykes
Address 6202 Sheriff Rd NE

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov 16, 1946 (month) (day) (year)

Cemetery or crematory Washington D.C.
Location

18. Funeral director Robert S. McGuire
Address 1820-9th St NW

19. Nov 16 1946 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12 1946 to Nov. 16 1946 and that I last saw him alive on Sept. 16 1946

Immediate cause of death	DURATION
Hypertensive Heart Disease Chr. Interstitial Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations no
Date of op. no
Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. H. Bruce M.D. M.D. or other
Address 5005 Sheriff Rd NE Date signed 11-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

11275

Reg. Diat. No. 2451

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

Baltimore & Ohio Tracks

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Mt Rainier Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5300 Tilden Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eugene Blair Truax

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 27, 1932

8. AGE: Years 14 Months Days If less than one day ... hrs. ... min.

9. Birthplace Benedict Md (Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Homer Truax

FATHER 13. Birthplace Pittsburg Pa

MOTHER 14. Maiden name Dorothy Brown

MOTHER 15. Birthplace Virginia

16. Informant Dorothy Truax

Address Decatur Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19, 1946 (month) (day) (year)

Cemetery or crematory Ft Lincoln

Location Colmar Manor Md

18. Funeral director F Gaschi sons

Address Hyattsville Md.

19. Nov. 19 1946 (Date rec'd by registrar) Madge Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1946, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death Hemorrhage and shock,	
Due to Internal Crushing wound of body head	
Due to and Contusions	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-15-46

Where did injury occur? Hyattsville (City or town) Pr. G. (County) Md (State)

Injured at home, farm, industry, public place (where?) B & O Tracks

Means of injury Struck by train Injured at work?

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Hyattsville Md Date signed 11-14-46

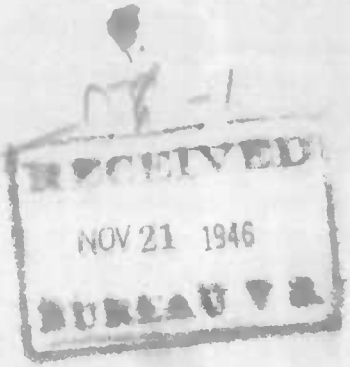
VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01-1

0-272-8



2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11276

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County: Prince George's Co.

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred: Prince George General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Washington D.C. County:

City or town: 2333 Eye st. N.W (If outside city or town limits, write RURAL and give nearest town)

Street No.: Washington D.C. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Thomas M Triggs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): — — 1894

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52				

9. Birthplace: Georgia (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business:

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: Ga

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: Ga

16. Informant: albert Hitchings

Address: 92 Myrtle st N.E Washington D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 3 1946 (month) (day) (year)

Cemetery or crematory: St Josephs Funeral Home

Location: 306 Eye st N.W Washington D.C.

18. Funeral director: E Gaschi sons

Address: Hyattsville Md

19. 11/3 1946 (Date rec'd by registrar) Amanda Deurey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1 1946, at 3.50 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M.D. or other

Address: Hyattsville Md Date signed 11-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11277

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 10 mos., 29 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 8 yrs., 10 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 70 Fenton St., N. E. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JOSEPH WASHINGTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1/13/16

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
30	10	7		

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: John Washington; 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Susie Washington; 15. Birthplace: Maryland

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 23, 1946 (month) (day) (year)

Cemetery or crematory: Woodmont Cemetery

Location: Prince George's Co., Md.

18. Funeral director: J. B. Robinson

Address: 34 Lafayette Ave, Annapolis, Md

19. Nov. 20 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20 1946, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 22 1937, to Nov. 20 1946

and that I last saw h.i.m. alive on Nov. 20 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	9½ yrs.
Due to: Tuberculous Empyema	9 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 11-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

11278

CERTIFICATE OF DEATH

Reg. Dist. No. 2450

1. PLACE OF DEATH:

County: Pr. Geo.

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years 5 hours

Hospital, institution, or street address where death occurred:

Leland Mem. Hospt.

How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. George.

City or town: Hyattsville.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sacred Heart Home.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ELIZABETH CELESTIA Whitacre

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed.

6.(b) Name of husband or wife: Albert Whitacre.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1871

8. AGE:

Years	Months	Days	If less than one day
75	2	13.	..... hrs. ..... min.

9. Birthplace: Pr. Geo. Cy., Md.

(Town, county, and state)

10. Usual occupation: H. wife.

11. Industry or business:

MOTHER FATHER

12. Name: Unknown

13. Birthplace:

MOTHER

14. Maiden name: Unknown.

15. Birthplace:

16. Informant: Charles E. Whitacre

Address: 1815 Mass. Ave. N.E.

17. Burial, cremation, or removal. Which?: Burial Date thereof: 11-22-46 (month) (day) (year)

Cemetery or crematory: Sts-11th St. S.E.

Location: Woodb. Va.

18. Funeral director: W. W. Chambers Co.

Address: 517-11th St. S.E.

19. Nov 22 1946 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 22, 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1933 to Nov 22 1946

and that I last saw her alive on Nov 21 1946

Immediate cause of death	DURATION
Congestive Heart Failure	2 days
Due to: Arteriosclerotic Heart Disease	13 y.
Due to: Cerebral Hemorrhage	3 days
Due to: Hemiplegia Dorsi	3 days
Other conditions: Coronary Thrombosis Nov 14 1934	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: T. W. Burch M. D. or other

Address: 208 Md Ave NE Date signed: Nov 22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11465

Reg. Dist. No. 2451

1. PLACE OF DEATH:
County: Prince Georges
City or town: East Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
6005 - 48th Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: East Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6005 - 48th Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #1 (S)

3.(a) FULL NAME: Ellis Walker Wood

3.(b) Social Security Number: 718-18-0365

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lottie M. Wood
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Feb 4, 1888

8. AGE:

Years	Months	Days	If less than one day
58	9	19	hrs. min.

9. Birthplace: Free Union Va (Town, county, and state)
10. Usual occupation: Foreman of Coach Cleaners
11. Industry or business: Washington Terminal
MOTHER FATHER
12. Name: Samuel Wood
13. Birthplace: Free Union, Va
MOTHER
14. Maiden name: Anna B. Powell
15. Birthplace: Free Union, Va
16. Informant: Lottie M. Wood
Address: 6005 - 48th Ave E. Riverdale, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-26-46 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Fort Myer, Va
18. Funeral director: Wood Chandler & Co
Address: Riverdale, Md.
19. Nov 24 1946 (Date rec'd by registrar) Mrs Jas Severe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 1946 at 6:00 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to: Cardiovascular Renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

Deputy medical Examiner
23. SIGNATURE: James J. Boyd M. D. or other
Address: Forestville Md. Date signed: 11-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-2450-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-0)

CERTIFICATE OF DEATH

★1279

Reg. Diat. No. 23-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Family moved in the last year to Welfare Board, Hyattsville, Md

1. PLACE OF DEATH:
County: Pr George
City or town: Chapel Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo
Hospital, institution, or street address where death occurred: 8910 Old Ft Rd SE
How long in hospital or institution? Private residence

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Geary Young

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 2. 1865

8. AGE: Years: 81 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Charles. Co. (Town, county, and state)

10. Usual occupation: Retired Laborer

11. Industry or business

FATHER — 12. Name / 13. Birthplace /

MOTHER — 14. Maiden name / 15. Birthplace /

16. Informant: Mrs. Bender
Address: Welfare Board - Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 28 1946 (month) (day) (year)
Cemetery or crematory: Chapel Hill
Location: Chapel Hill Md

18. Funeral director: Robert G Mason
Address: 2500 Nichols Av. S E.

19. Nov. 25 1946 Mrs Alton Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 25 1946, at 3:50 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 15 1946 to Nov 25 1946 and that I last saw h.. alive on Nov 24 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis } more than	1 mo
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings at operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G W Seward M.D.
Address: 225 Talbot Ave Wash (20) D C
M. D. or other
Date signed: Nov 25 1946